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Chippewa Falls, WI 54729

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WINN FAMILY DENTISTRY

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Eaglesoft Medical History

Patient Name: _____ **Date of Birth:** _____ **Gender: M / F**

Preferred Pronouns: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now? (other than routine) ☐ Yes ☐ No If Yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If Yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If Yes _____

Do you require pre-medication for artificial joint replacement? ☐ Yes ☐ No If Yes _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If Yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If Yes _____

Are you on a special diet? ☐ Yes ☐ No If Yes _____

Do you use tobacco? (if yes list chewing tobacco or smoking and indicate frequency) ☐ Yes ☐ No If Yes _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances? ☐ Yes ☐ No If Yes _____

Other? ☐ If Yes _____

Medications: _____

Do you have, or have you had, any of the following? (Yes - Y/ No - N)

AIDS/HIV Positive	☐ Y ☐ N	Cold Sores/Fever Blisters	☐ Y ☐ N	Genital Herpes	☐ Y ☐ N	Irregular Heartbeat	☐ Y ☐ N	Rheumatism	☐ Y ☐ N
Alzheimer's Disease	☐ Y ☐ N	Congenital Heart Disorder	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Anaphylaxis	☐ Y ☐ N	Convulsions	☐ Y ☐ N	Hay Fever	☐ Y ☐ N	Leukemia	☐ Y ☐ N	Shingles	☐ Y ☐ N
Anemia	☐ Y ☐ N	Yellow Jaundice	☐ Y ☐ N	Heart Attack/Failure	☐ Y ☐ N	Liver Disease	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
Angina	☐ Y ☐ N	Cortisone Medicine	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N
Arthritis/Gout	☐ Y ☐ N	Diabetes Yes No	☐ Y ☐ N	Heart Pacemaker	☐ Y ☐ N	Lung Disease	☐ Y ☐ N	Spina Bifida	☐ Y ☐ N
Artificial Heart Valve	☐ Y ☐ N	Drug Addiction	☐ Y ☐ N	Heart Trouble/Disease	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Stomach/Intestinal Disease	☐ Y ☐ N
Artificial Joint	☐ Y ☐ N	Easily Winded	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Stroke	☐ Y ☐ N
Asthma	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Hepatitis A	☐ Y ☐ N	Pain in Jaw Joints	☐ Y ☐ N	Swelling of Limbs	☐ Y ☐ N
Blood Disease	☐ Y ☐ N	Epilepsy or Seizures	☐ Y ☐ N	Hepatitis B or C	☐ Y ☐ N	Parathyroid Disease	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Excessive Bleeding	☐ Y ☐ N	Herpes	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Breathing Problems	☐ Y ☐ N	Excessive Thirst	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Radiation Treatments	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Bruise Easily	☐ Y ☐ N	Fainting Spells/Dizziness	☐ Y ☐ N	High Cholesterol	☐ Y ☐ N	Recent Weight Loss	☐ Y ☐ N	Tumors or Growths	☐ Y ☐ N
Cancer	☐ Y ☐ N	Frequent Cough	☐ Y ☐ N	Hives or Rash	☐ Y ☐ N	Renal Dialysis	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Chemotherapy	☐ Y ☐ N	Frequent Diarrhea	☐ Y ☐ N	Hypoglycemia	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
Chest Pains	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N						

Have you ever had any serious illness not listed ☐ Yes ☐ No If Yes _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is rny responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date** _____